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# Health Reports

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## PREFACE

Health Reports is a list of health-related products, including reports and testimonies issued by the General Accounting Office (GAO) over the past 2 years. Organized chronologically, the entries provide a title, report number, and issue date for each GAO health-related product. Reports and testimonies on the same topic may be combined into a single entry.

The first section--Recent GAO Health Products--summarizes reports and testimonies on selected health issues published during the past 4 months. This section is followed by a list of additional products published during the same period and then a section listing summaries of most frequently requested health reports. The remainder of Health Reports is a list of health-related products published during the past 2 years and organized by subject areas as shown in the table of contents. As appropriate, entries have been cross-indexed and are included in more than one subject area. Order forms to be placed on our mailing list for Health Reports and to request GAO products appear at the end of this publication.



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## ABBREVIATIONS

ADMS	Alcohol, Drug Abuse and Mental Health Services
ADP	automatic data processing
AIDS	acquired immunodeficiency syndrome
CDC	Centers for Disease Control and Prevention
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DC	District of Columbia
DOD	Department of Defense
DOE	Department of Energy
ERISA	Employee Retirement Income Security Act of 1974
EPA	Environmental Protection Agency
FDA	Food and Drug Administration
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HealthPASS	Philadelphia Accessible Services System
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HMO	health maintenance organization
IHS	Indian Health Service
IRS	Internal Revenue Service
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MRI	magnetic resonance imaging
NAIC	National Association of Insurance Commissioners
OSHA	Occupational Safety and Health Administration
PHS	HHS Public Health Service
RBRVS	Medicare Resource-Based Relative Value Scale
SSA	Social Security Administration
USDA	United States Department of Agriculture
VA	Department of Veterans Affairs
WIC	Special Supplemental Food Program for Women, Infants, and Children

**RECENT GAO HEALTH PRODUCTS**  
(May-August 1993)

**SUMMARIES OF SELECTED REPORTS**

**Health Care Access: Innovative Programs Using Nonphysicians**  
(Report, Aug. 27, 1993, GAO/HRD-93-128).

This report describes (1) a unique method used by the Indian Health Service (IHS) to deliver emergency and primary care in remote Alaska villages and (2) a Florida county's plans to use aspects of this method to provide health care services in a medically underserved urban setting. The Alaska program trains local residents to provide emergency and primary care services in villages, which are often hundreds of miles away from the nearest physician. The Pinellas County Emergency Medical Services of Florida, whose service area includes medically underserved areas in St. Petersburg, has proposed adapting key aspects of the Alaska program in order to increase access to primary care.

**Long-Term Care Insurance: High Percentage of Policyholders Drop Policies** (Report, Aug. 25, 1993, GAO/HRD-93-129).

A high percentage of policyholders will likely let their policies lapse before they receive any covered services. Unless there is a provision in the policy, these policyholders would not get a return from the premiums they paid. In this study, sales commissions paid by companies for the first year of the policy averaged about 60 percent of the total value of the first year's premium. As reported previously in Long-Term Care Insurance: Risks to Consumers Should Be Reduced (Report, Dec. 26, 1991, GAO/HRD-92-14), many states have not adopted the National Association of Insurance Commissioners (NAIC) model for reporting lapse rates and commission rates. State adoption of the NAIC provisions would strengthen monitoring of policies by state insurance commissioners and provide greater protection to consumers who buy them.

**Medical Malpractice: Medicare/Medicaid Beneficiaries Account for a Relatively Small Percentage of Malpractice Losses** (Report, Aug. 11, 1993, GAO/HRD-93-126).

Medicare and Medicaid patients are less likely than other patients to file malpractice claims. When they file claims, their awards or settlements are significantly lower than those for patients with other health insurance. From October 1985 through September 1990, Medicare and Medicaid patients received about one-fourth of the \$2.3 billion of hospital malpractice awards, although they represent more than 45 percent of hospital patients. While Medicare patients' percentage of hospital malpractice awards is significantly lower than their portion of hospital discharges, Medicaid patients' percentage is slightly higher than their discharge rate.

Preventive Health Care for Children: Experience From Selected Foreign Countries (Report, Aug. 4, 1993, GAO/HRD-93-62).

Although England, France, Germany, Japan, and the Netherlands provide universal access to health care for all children, they do not rely solely on systems of universal coverage to ensure that all children receive preventive services. Instead, these countries do one or more of the following: (1) notify health authorities of new births, (2) target new parents for home visits, (3) provide booklets for maintaining a child's health record, (4) provide physical exams and immunizations in schools, and (5) facilitate the continuity of care through computerized tracking systems.

Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (Report, Aug. 2, 1993, GAO/HRD-93-118). Testimony on same topic (Aug. 2, 1993, GAO/T-HRD-93-28).

Twenty-one of the Medicaid Fraud Control Unit directors told GAO of problems involving drug diversion. Several factors, including data inadequacies and staff shortages, complicate attempts to curb drug diversion schemes. States are taking steps to address these problems, but despite local success stories, drug diversion persists. State agencies do not follow up cases of potential diversion. States and federal agencies also fail to use their authority to impose sanctions and recover program losses. Offenders frequently retain some connection with health care delivery, with the consequent opportunity for future violations.

VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (Report, July 29, 1993, GAO/HRD-93-94).

The complex eligibility and entitlement provisions of the Department of Veterans Affairs (VA) place more restrictions on the availability of services than do other programs. About two-thirds of veterans eligible for VA care can obtain medical services only to the extent that space and resources are available after other veterans with higher priorities for care are served. Other public and private health care programs essentially guarantee payment for covered services to all eligible participants. Once in the VA system, veterans are generally offered a more extensive array of services, fewer limitations in terms of the duration and number of visits or services covered, and less cost sharing than are available under most public and private health benefit programs.

VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (Report, July 27, 1993, GAO/HRD-93-68).

VA could potentially offset a significant portion of its nursing home and domiciliary care costs if it had the same authority states have to operate estate recovery programs under Medicaid. The potential for recovering nursing home and domiciliary costs may be greater for veterans than for Medicaid recipients because (1) home

ownership is significantly higher among elderly VA hospital users than among Medicaid nursing home recipients, and (2) veterans living in VA facilities generally contribute much less of their incomes toward the cost of their care than do Medicaid recipients. Oregon's successful Medicaid estate recovery program could serve as a model for a VA program.

Nonprofit Hospitals: For-Profit Ventures Pose Access and Capacity Problems (Report, July 22, 1993, GAO/HRD-93-124).

In 1991, according to American Hospital Association data, about 18 percent of nonprofit hospitals were participating in joint ventures with physicians. The 23 joint ventures we reviewed in depth provided significantly less care to Medicaid and charity patients than their parent hospitals provided. These joint ventures provided evidence that such projects can contribute to excess capacity for medical services in their communities.

Medicare: Separate Payment for Fitting Braces and Artificial Limbs Is Not Needed (Report, July 21, 1993, GAO/HRD-93-98).

Separate fees for professional services are not necessary because Medicare's payment amounts for braces and artificial limbs already include a component for the practitioner's professional services. With the assistance of two industry groups, we identified 42 items paid for under the orthotic and prosthetic fee schedule that do not require professional fabrication or fitting services. We also identified considerable variation in coverage criteria for braces and artificial limbs among Medicare's claims processing contractors. Medicare's December 1992 action to reduce the number of contractors that pay brace and artificial limb claims from 54 to 4 should remedy this problem and result in the use of more consistent criteria.

Medicare Physician Payment: Geographic Adjusters Appropriate But Could Be Improved With New Data (Report, July 20, 1993, GAO/HRD-93-93).

The Health Care Financing Administration (HCFA) actively sought and tested numerous data sources when developing the geographic adjusters and made reasonable data and methodology choices, considering the time constraints under which the adjusters were developed. We found that the Internal Revenue Service (IRS) has data available that could prove beneficial when the adjusters are updated. HCFA did not use IRS data in developing the current practice-cost adjuster because it did not believe that the technical and legal impediments to using these data could be overcome in the available time. Currently, HCFA is working with IRS to assess the feasibility of using IRS data in updating the adjusters.

VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (Report, July 16, 1993, GAO/HRD-93-106).

Veterans' access to outpatient care at VA medical centers varies widely for two reasons: (1) medical centers interpret VA outpatient eligibility criteria differently, and (2) medical centers' rationing decisions vary, including whether to ration and what rationing method to use. This variation results in veterans with similar medical conditions or income status receiving outpatient care at some medical centers but not at others.

VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (Report, July 14, 1993, GAO/HRD-93-123).

Of 198 veterans surveyed, 168 (85 percent) obtained needed care after VA medical centers turned them away. These veterans received diagnostic evaluations or needed treatment, including medication, for the same conditions for which they had initially sought treatment at the VA centers. The remaining 30 veterans did not obtain further medical care, primarily because they could not afford it.

1993 German Health Reforms: New Cost Control Initiatives (Report, July 7, 1993, GAO/HRD-93-103).

Sharp increases in the mandated health insurance premium paid by most workers and retirees triggered the 1993 German health care reforms. The government-imposed emergency global budget controls will remain in effect for the next 3 years to give the health care industry time to change the structure of the health care sector. These changes are expected to sufficiently reduce cost pressure so that federally imposed budget limits become unnecessary. The new reforms have initiatives to improve equity and stimulate competition in Germany's multiple third-party payer system. The reforms are expected to generate net savings of about \$6.3 billion or about 6 percent of total sickness-fund spending in 1992.

FDA Regulation of Dietary Supplements (Letter, July 2, 1993, GAO/HRD-93-29R).

The Food and Drug Administration (FDA) regulates dietary supplement companies on a case-by-case basis as it receives complaints or other information concerning a product's safety or labeling. Preliminary information we obtained from FDA indicates that from fiscal year 1989 to 1992 FDA had taken action against about 290 companies that manufactured or marketed dietary supplements. FDA estimated that, between fiscal years 1988 and 1992, the amount of resources expended to address reported problems or complaints involving dietary supplements ranged from 13 to 57 of the agency's 3,400 full-time-equivalent employees.

Hospital Sterilants: Insufficient FDA Regulation May Pose a Public Health Risk (Report, June 14, 1993, GAO/HRD-93-79).

The Environmental Protection Agency (EPA) and FDA acted correctly in halting the sale of Sporicidin Cold Sterilizing Solution and other products that are disinfectants in December 1991. Although FDA took proper action against Sporicidin International, its overall regulation of other manufacturers of hospital sterilants and disinfectants has been inadequate. In this regard, only a few sterilant and disinfectant manufacturers have registered their products with FDA, and few of the hundreds have been authorized for marketing by FDA, as required by law.

Private Health Insurance: Wide Variation in State Insurance Departments' Regulatory Authority (Testimony, May 27, 1993, GAO/T-HRD-93-25).

GAO discussed how state insurance departments regulate health insurance, the resources they commit to these efforts, and the implications that health care reform could have on state insurance departments' roles and responsibilities. The departments' authority extends over only part of the market and varies widely among states. Past GAO studies have raised serious questions about the effectiveness of states' efforts to monitor insurer financial solvency. In our current survey, GAO found wide variations in states' practices and procedures for approving premium rates and policies. Any health reform plan adopted should clearly specify expectations for the departments in enforcing whatever new requirements may be imposed on health insurers.

VA Health Care: Problems in Implementing Locality Pay for Nurses Not Fully Addressed (Report, May 21, 1993, GAO/HRD-93-54).

VA's procedures for surveying local salary rates fell well short of the standards established for Bureau of Labor Statistics surveys. As a result, VA's salary rates could easily be substantially higher or lower than justified. GAO believes that the potential for errors is sufficient and that the process should be reported as a material internal control weakness. VA officials attribute this shortcoming to the limited time available to implement the locality pay system. The problems were not, however, corrected during the second round of surveys, and most still have not been addressed 18 months after implementation of the system.

Medical Malpractice: Experience with Efforts to Address Problems (Testimony, May 20, 1993, GAO/T-HRD-93-24).

The states and the private sector have initiated a number of efforts to address the problems associated with an inefficient and inequitable compensation system and the adverse effects on the way physicians practice medicine. Four of these efforts currently receiving considerable attention are (1) risk management at the

Harvard medical institutions, (2) the use of practice guidelines in Maine, (3) alternatives to litigation in several states and some health maintenance organizations (HMOs), and (4) no-fault approaches in Virginia and Florida. Any reform of the malpractice system should address the issues of (1) reducing the incidence of negligent care, (2) fairly compensating individuals injured through medical negligence, and (3) dealing with the complexities involved in efforts to enhance the overall quality of care provided in the United States.

VA Health Care: Enforcement of Federal Ethics Requirements at VA Medical Centers (Testimony, May 19, 1993, GAO/T-HRD-93-22). Reports on same topic (May 12, 1993, GAO/HRD-93-39S and Apr. 30, 1993, GAO/HRD-93-39).

Senior managers at nearly one-third of the VA medical centers reported receiving part-time employment incomes, averaging thousands of dollars, from medical schools that receive millions of dollars through VA contracts. Nevertheless, VA has allowed these managers to participate in awarding and administering these contracts. This potential conflict of interest raises serious questions about the ability of VA managers to maintain their independence and impartiality. Such activities are prohibited under federal conflict-of-interest regulations and may violate federal criminal statutes. These activities not only subject managers to possible prosecution but also significantly impair the integrity of VA's procurement process.

Medicare: Renal Facility Cost Reports Probably Overstate Costs of Patient Care (Report, May 18, 1993, GAO/HRD-93-70).

GAO randomly selected 30 Medicare audits of 124 dialysis facility cost reports and found that the audits were incomplete and poorly done. If the audits had been adequately performed, additional costs would probably have been disallowed and removed from the cost reports. This would have resulted in a further reduction of the median cost per treatment. Cost report data show that vertically integrated firms (those that own manufacturing, pharmacy, and dialysis facilities) and horizontally integrated firms (those that own a group of dialysis facilities) provided dialysis treatments at a substantially lower cost than nonintegrated firms (those that own only one dialysis facility).

Medicaid: HealthPASS--An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (Report, May 7, 1993, GAO/HRD-93-67).

GAO reviewed certain aspects of the Philadelphia Accessible Services System (HealthPASS) and found that (1) women who seek pregnancy-related care are receiving quality services, but they did not avail themselves of this care early or often enough, (2) premature and low birth weight babies were delivered with great

frequency by both HealthPASS and fee-for-service providers, (3) some HealthPASS providers were not furnishing children with required and timely preventive care services, and (4) enrollment of eligible HealthPASS members in the Special Supplemental Food Program for Women, Infants, and Children (WIC) is no greater than the enrollment of eligible Medicaid fee-for-service women and children.

ADDITIONAL GAO HEALTH PRODUCTS ISSUED BETWEEN MAY AND AUGUST 1993

CDC's Mission and Duplication in PHS (Letter, Aug. 30, 1993, GAO/HRD-93-32R).

Medicaid: Alternatives for Improving the Distribution of Funds to States (Report, Aug. 20, 1993, GAO/HRD-93-112FS).

Medicare Part B: Reliability of Claims Processing Across Four Carriers (Report, Aug. 11, 1993, GAO/PEMD-93-27).

Operation Desert Storm: Army Medical Supply Issues (Report, Aug. 11, 1993, GAO/NSIAD-93-206).

Operation Desert Storm: Improvements Required in the Navy's Wartime Medical Care Program (Report, July 28, 1993, GAO/NSIAD-93-189).

Veterans Affairs: Accessibility of Outpatient Care at VA Medical Centers (Testimony, July 21, 1993, GAO/T-HRD-93-29).

Medicaid Estate Planning (Letter, July 20, 1993, GAO/HRD-93-29R).

Retiree Health Plans: Health Benefits Not Secure Under Employer-Based System (Report, July 9, 1993, GAO/HRD-93-125).

Social Security Disability: SSA Needs to Improve Continuing Disability Review Program (Report, July 8, 1993, GAO/HRD-93-109).

Medical Readiness Training: Limited Participation by Army Medical Personnel (Report, June 30, 1993, GAO/NSIAD-93-205).

Federal Employment: Inquiry Into Sexual Harassment Issues at Selected VA Medical Centers (Report, June 30, 1993, GAO/GGD-93-119).

Federal Health Care: Increased Information Sharing Could Improve Service, Reduce Costs (Report, June 29, 1993, GAO/IMTEC-93-33BR).

Drug Use Measurement: Strengths, Limitations, and Recommendations for Improvement (Report, June 25, 1993, GAO/PEMD-93-18).

Overhead Costs: Unallowable and Questionable Costs Charged to Medicare by Hospital Corporation of America (Testimony, June 23, 1993, GAO/T-NSIAD-93-16).

Long-Term Care Insurance: Tax Preferences Reduce Costs More for Those in Higher Tax Brackets (Report, June 22, 1993, GAO/GGD-93-110).

VA Health Care: Delays in Awarding Major Construction Contracts (Report, May 26, 1993, GAO/HRD-93-101).

DOD Health Care: Further Testing and Evaluation of Case-Managed Home Care Is Needed (Report, May 21, 1993, GAO/HRD-93-59).

Massachusetts Long-Term Care (Letter, May 17, 1993, GAO/HRD-93-22R).

Safety and Health: Key Independent Oversight Program at DOE Needs Strengthening (Report, May 17, 1993, GAO/RCED-93-85).

Medicaid: Data Improvements Needed to Help Manage Health Care Program (Report, May 13, 1993, GAO/IMTEC-93-18).

Defense Health Care: Lessons Learned From DOD's Managed Health Care Initiative (Testimony, May 10, 1993, GAO/T-HRD-93-21).

Defense Health Care: Additional Improvements Needed to CHAMPUS's Mental Health Program (Report, May 6, 1993, GAO/HRD-93-34).

Veterans' Health Care: Potential Effects of Health Care Reforms on VA's Major Construction Program (Testimony, May 6, 1993, GAO/T-HRD-93-19).

Veterans' Affairs: Establishing Patient Smoking Areas at VA Facilities (Report, May 3, 1993, GAO/HRD-93-104).

## MOST FREQUENTLY REQUESTED HEALTH REPORTS

Health Care: Rochester's Community Approach Yields Better Access, Lower Costs (Report, Jan. 29, 1993, GAO/HRD-93-44).

Rochester, New York, has succeeded in keeping health care costs lower than costs in other communities without sacrificing its residents' access to care. Rochester residents are more likely to have health insurance than are people living elsewhere in the nation. Rochester's system is distinguished by the interaction of several factors, beginning with a long history of community-based health planning. These planning initiatives have included limiting the expansion of hospital capacity, implementing global budgeting that capped total hospital revenues, and controlling the diffusion of medical technology.

Emergency Departments: Unevenly Affected by Growth and Change in Patient Use (Report, Jan. 4, 1993, GAO/HRD-93-4).

Nationwide emergency department patient caseloads grew dramatically from 1985 through 1990. Growth was concentrated among patients whose medical care is often not reimbursed, such as the uninsured and Medicaid patients in some states. This disproportionate growth may make it more difficult for hospitals to absorb or offset losses due to unreimbursed emergency department patient care costs. Nationwide patterns of caseload growth, payer mix, and timeliness of care conceal substantial variations in emergency department conditions among hospitals.

Prescription Drugs: Companies Typically Charge More in the United States Than in Canada (Report, Sept. 30, 1992, GAC/HRD-92-110).

Manufacturers' prices to wholesalers for identical prescription drugs are typically higher in the United States than in Canada. The price differences are largely attributable to actions taken by Canada's federal and provincial governments to restrain drug prices, not to any differences in manufacturers' costs in the two countries. The implications of adopting Canadian regulations in the United States are in dispute. It is not clear how such regulations would affect manufacturers' ability to develop innovative drug products.

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (Report, Sept. 22, 1992, GAO/HRD-92-125).

Many employers are facing rapidly increasing health insurance premiums and are frustrated by their unsuccessful efforts to contain health care costs. Firms most vulnerable to rising health costs are those whose health insurance plans offer extensive benefits and cover a large number of retirees or dependents; those whose workers are older, less healthy, or earning higher incomes; those with relatively few workers; and those in high health-cost

areas. Individual firms can do little to lower their health care costs because they cannot readily change their size, location, or employee demographics.

Access to Health Care: States Respond to Growing Crisis (Report, June 16, 1992, GAO/HRD-92-70). Testimony on same topic (June 9, 1992, GAO/T-HRD-92-40).

States have taken a leadership role in devising strategies to expand access to health insurance and contain the growth of health costs. A difficult hurdle to overcome, however, is the restrictions imposed by the preemption clause of the Employee Retirement Income Security Act of 1974 (ERISA). This clause effectively prevents states from exercising control over all employer-provided insurance. Hawaii is the only state with an exemption, in part because its law requiring employer-provided health insurance took effect before ERISA was enacted. Other states have tried to move toward coverage of all their citizens within ERISA's constraints. Some state initiatives have been more narrowly focused, creating programs to assist specific groups. State budgetary constraints, however, have limited these programs to serving a small fraction of the uninsured population.

Medicare: Excessive Payments Support the Proliferation of Costly Technology (Report, May 27, 1992, GAO/HRD-92-59).

In some localities, Medicare's technical component payments for magnetic resonance imaging (MRI) do not reflect the lower costs per scan now being achieved through faster scanning and higher machine utilization. Current payment levels are based, in part, on the charges allowed by local Medicare contractors in the mid-1980s. The 1991 payment levels in some localities were more than twice as high as in others, reflecting wide geographic disparities in the historical allowed charges. Medicare should base its payments on the costs incurred by high-volume, efficient facilities to reduce Medicare program expenditures and to discourage providers from adding excess capacity to the health care system.

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (Report, May 7, 1992, GAO/HRD-92-69). Testimony on same topic (May 7, 1992, GAO/T-HRD-92-29).

Weaknesses within the health insurance system allow unscrupulous health care providers to cheat insurance companies and programs out of billions of dollars annually. Repairing the system's weaknesses presents a dilemma to policymakers: on the one hand, safeguards must be adequate for prevention, detection, and pursuit; on the other, they must not be unduly burdensome or intrusive for policyholders, providers, insurers, and law enforcement officials. GAO has asked the Congress to consider establishing a national health care fraud commission as a way to unite the efforts of

public and private payers and to build consensus among representatives of divergent viewpoints.

Health Care Spending Control: The Experience of France, Germany, and Japan (Report, Nov. 15, 1991, GAO/HRD-92-9). French and German translations available (Nov. 15, 1991, GAO/HRD-92-9ES). Testimony on same topic (Nov. 19, 1991, GAO/T-HRD-92-12).

France, Germany, and Japan achieve near-universal health insurance coverage. This report describes these countries' health insurance and financing methods, their policies intended to restrain health care spending increases, and the effectiveness of these policies. While GAO does not endorse the specific health systems in the reviewed countries, their strengths and weaknesses could be instructive in helping resolve U.S. health care problems.

U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform (Report, June 10, 1991, GAO/HRD-91-102). French and German translations available (June 10, 1991, GAO/HRD-91-102). Testimony on same topic (Apr. 17, 1991, GAO/T-HRD-91-16).

This report contains April 17, 1991, testimony presented to the House Committee on Ways and Means on health care costs in the United States as well as on long-term strategies for reform of the U.S. health care system.

Canadian Health Insurance: Lessons for the United States (Report, June 4, 1991, GAO/HRD-91-90). Testimony on same topic (June 4, 1991, GAO/T-HRD-91-35).

If the universal coverage and single-payer features of the Canadian system were applied in the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for the millions of Americans who are uninsured. Enough would be left over to permit a reduction, or possibly even the elimination, of copayments and deductibles. With the authority and responsibility to oversee the system as a whole, as in Canada, the single payer could potentially constrain the growth in long-run health care costs. Canadians have few problems with access to primary care services. The Canadian method of controlling hospital costs has limited the use of expensive, high-technology diagnostic and surgical procedures.

## HEALTH FINANCING AND ACCESS

Health Care Access: Innovative Programs Using Nonphysicians  
(Report, Aug. 27, 1993, GAO/HRD-93-128).

Nonprofit Hospitals: For-Profit Ventures Pose Access and Capacity Problems (Report, July 22, 1993, GAO/HRD-93-124).

1993 German Health Reforms: New Cost Control Initiatives (Report, July 7, 1993, GAO/HRD-93-103).

Organ Transplants: Increased Effort Needed to Boost Supply and Ensure Equitable Distribution of Organs (Report, Apr. 22, 1993, GAO/HRD-93-56). Testimony on same topic (Apr. 22, 1993, GAO/T-HRD-93-17).

Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (Testimony, Mar. 8, 1993, GAO/T-HRD-93-8).

Major Issues Facing a New Congress and a New Administration (Testimony, Jan. 8, 1993, GAO/T-OCG-93-1).

Health Insurance: Legal and Resource Constraints Complicate Efforts to Curb Fraud and Abuse (Testimony, Feb. 4, 1993, GAO/T-HRD-93-3). Report on same topic (May 7, 1992, GAO/HRD-92-69). Testimony on same topic (May 7, 1992, GAO/T-HRD-92-29).

Health Care: Rochester's Community Approach Yields Better Access, Lower Costs (Report, Jan. 29, 1993, GAO/HRD-93-44).

Emergency Departments: Unevenly Affected by Growth and Change in Patient Use (Report, Jan. 4, 1993, GAO/HRD-93-4).

Transition Series: Health Care Reform (Report, Dec. 1992, GAO/OCG-93-STR).

Removal of Breast Implants (Letter, Dec. 7, 1992, GAO/HRD-93-5R).

Bone Marrow Transplants: National Program Has Greatly Increased Pool of Potential Donors (Report, Nov. 4, 1992, GAO/HRD-93-11).

Trauma Care Reimbursement: Poor Understanding of Losses and Coverage for Undocumented Aliens (Report, Oct. 15, 1992, GAO/PEMD-93-1).

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (Report, Sept. 22, 1992, GAO/HRD-92-125).

Hospital Costs: Adoption of Technologies Drives Cost Growth (Report, Sept. 9, 1992, GAO/HRD-92-120).

State Health Care Reform: Federal Requirements Influence State Reforms (Testimony, Sept. 9, 1992, GAO/T-HRD-92-55). Report on same topic (June 16, 1992, GAO/HRD-92-70). Testimony on same topic (June 9, 1992, GAO/T-HRD-92-40).

Health Insurance: More Resources Needed to Combat Fraud and Abuse (Testimony, July 28, 1992, GAO/T-HRD-92-49).

Access to Health Care: States Respond to Growing Crisis (Report, June 16, 1992, GAO/HRD-92-70). Testimony on same topic (June 9, 1992, GAO/T-HRD-92-40).

Federally Funded Health Services: Information on Seven Programs Serving Low-Income Women and Children (Report, May 28, 1992, GAO/HRD-92-73FS).

Access to Health Insurance: States Attempt to Correct Problems in Small Business Health Insurance Market (Report, May 14, 1992, GAO/HRD-92-90). Testimony on same topic (May 14, 1992, GAO/T-HRD-92-30).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (Report, May 7, 1992, GAO/HRD-92-69). Testimony on same topic (May 7, 1992, GAO/T-HRD-92-29).

Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guaranty Funds (Testimony, Apr. 28, 1992, GAO/T-GGD-92-15). Report on same topic (Mar. 19, 1992, GAO/GGD-92-44).

Early Intervention: Federal Investments Like WIC Can Produce Savings (Report, Apr. 7, 1992, GAO/HRD-92-18).

Maternal and Child Health: Block Grant Funds Should Be Distributed More Equitably (Report, Apr. 2, 1992, GAO/HRD-92-5).

Health Care: Problems and Potential Lessons for Reform (Testimony, Mar. 27, 1992, GAO/T-HRD-92-23).

Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guaranty Funds (Report, Mar. 19, 1992, GAO/GGD-92-44).

Small Group Market Reforms: Assessment of Proposals to Make Health Insurance More Readily Available to Small Businesses (Letter, Mar. 12, 1992, GAO/HRD-92-27R).

Medigap Insurance: Insurers Whose Loss Ratios Did Not Meet Federal Minimum Standards in 1988-89 (Report, Feb. 28, 1992, GAO/HRD-92-54).

Health Care Spending: Nonpolicy Factors Account for Most State Differences (Report, Feb. 13, 1992, GAO/HRD-92-36).

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